Commonwealth of Massachusetts
Group Insurance Commission
Your Benefits Connection

The Commonwealth of Massachusetts
Group Insurance Commission

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GROUP *HEALTH CARE SPENDING ACCOUNT*
CONTINUATION COVERAGE UNDER COBRA
NOTICE

You are receiving this notice because you participate in the Group Insurance Commission's (GIC's) Health Care Spending Account program. This notice contains important information about your right to continue your participation if your HCSA coverage otherwise would end due to certain life events. Please read it carefully.

WHAT IS COBRA HEALTH CARE SPENDING ACCOUNT COVERAGE? COBRA is a federal law under which certain former employees, spouses, former spouses and dependent children have the right to temporarily continue to participate in the GIC's Health Care Spending Account (HCSA) program if their coverage otherwise would end due to certain life events, called 'Qualifying Events.' COBRA HCSA allows enrollees to make payments on an after tax basis for the remainder of the Plan Year; therefore, participating enrollees will not reduce their taxes by electing COBRA HCSA coverage.

If you elect COBRA HCSA coverage, you are entitled to the same coverage rights under the Plan as other Plan participants or beneficiaries. Until the end of the Plan Year, you may continue to submit documentation to reimburse eligible expenses incurred after your Qualifying Event for those months in which you make your after-tax payment.

WHO IS ELIGIBLE FOR COBRA HCSA COVERAGE? Qualified Beneficiaries may elect to continue their HCSA coverage that otherwise would end due to termination of employment or reduction in hours, death, legal separation, divorce, or ceasing to be a dependent child under GIC eligibility rules. Each individual entitled to COBRA has an independent right to elect the coverage, regardless of whether or not other eligible family members elect it.

HOW LONG DOES COBRA HCSA COVERAGE LAST? COBRA HCSA coverage may be continued until the end of the Plan year in which the qualifying event occurs and may not be extended any longer than that period.

HOW AND WHEN DO I ELECT COBRA HCSA COVERAGE? Qualified beneficiaries must elect COBRA HCSA coverage within 60 days of the date that their HCSA participation otherwise would end or within 60 days of receiving a COBRA notice, whichever is later, by sending a completed COBRA HCSA Election Form to the plan administrator. A qualified beneficiary may change a prior rejection of COBRA election any time until that date. **If you do not elect COBRA HCSA coverage within the 60–day election period, you will lose all rights to COBRA HCSA coverage**.

HOW DO I MAKE MY PAYMENTS UNDER COBRA HCSA COVERAGE?
COBRA HCSA payments are due on the first of each month. You are allowed a grace period of thirty (30) days from the first of each month to submit your payment. Payment not received by the end of the grace period will result in termination of your HCSA COBRA coverage, **and you will lose all rights to COBRA coverage.**

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES
In order to protect your rights to COBRA HCSA coverage, keep the GIC and the plan administrator informed of any changes in your address and that of family members. For your records, you should also keep a copy of any notices you send to the GIC and the administrator.

COBRA coverage is provided subject to your eligibility. The GIC and the plan administror reserve the right to terminate your COBRA coverage retroactively if you are determined to be ineligible for coverage. For additional information about COBRA HCSA benefits, contact the plan administrator. You may also contact the U.S. Department of Labor Employee Benefits Security Administration's website at **www.dol.gov/ebsa.**

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Health Care Spending Account COBRA Application for Employees Leaving State Service/Unpaid Leave of Absence

Name: _____

(Please print)

State Agency/Department where last employed: _____

Date of Termination: _____

Date of Unpaid Leave of Absence: _____

Date of Birth: _____

Social Security Number: _____

Home Address: _____

_____

Phone Number: _____

Email Address: _____

_____ _____

(Signature) **(Date)**

Mail or fax completed form to:
SHPS Spending Accounts
PO Box 34700
Louisville, KY 40232
FAX 1.866.643.2219

Call SHPS at 1.866.862.2422 to confirm your monthly post-tax HCSA contribution while on COBRA.

THIS SECTION TO BE COMPLETED BY SHPS

Monthly Post Tax HCSA Contribution amount: _____

Effective Date: _____

Signed by SHPS: _____